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Community, Service, and Policy Strategies to Improve Health Care Access in the Changing Urban Environment

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A B S T R A C T

Urban communities continue to face formidable historic challenges to improving public health. However, reinvestment initiatives, changing demographics, and growth in urban areas are creating changes that offer new opportunities for improving health while requiring that health systems be adapted to residents' health needs.

This commentary suggests that health care improvement in metropolitan areas will require setting local, state, and national agendas around 3 priorities. First, health care must reorient around powerful population dynamics, in particular, cultural diversity, growing numbers of elderly, those in welfare–workplace transition, and those unable to negotiate an increasingly complex health system. Second, communities and governments must assess the consequences of health professional shortages, safety net provider closures and conversions, and new marketplace pressures in terms of their effects on access to care for vulnerable urban populations; they must also weigh the potential value of emerging models for improving those populations' care. Finally, governments at all levels should use their influence through accreditation, standards, tobacco settlements, and other financing streams to educate and guide urban providers in directions that respond to urban communities' health care needs. (*Am J Public Health*. 2000; 90:858–862)

Improving the health of residents of the nation's urban areas has been a formidable and continuing struggle to meet complex and varied needs with limited resources. Entrenched chronic conditions such as asthma, diabetes, and cancer; infant mortality and child morbidity; drug abuse; violent crime; and health-risk behavior have been accompanied by chronic health system problems of difficult access to and inconsistent quality of care. These circumstances intersect with inner-city environments, requiring providers to recognize not only the specific medical challenge but also the complex social context within which individuals work and live.

Despite these long-standing conditions, cities are not stagnant, isolated enclaves, doomed to face ever-growing challenges to the health of their citizens. As this commentary discusses, recent research has demonstrated that access to effective health-related interventions can improve the lives of urban residents. Moreover, several health and social dynamics suggest both new opportunities and emerging concerns that demand reconsideration of the nation's health care policy and programs as they relate to health and health care in urban areas. The composition of many of these communities is changing, with the aging of the population, metropolitan area sprawl, and growing cultural diversity altering the terrain.

Overlaying these changes are other contrasting dynamics. For example, many cities are witnessing an urban renaissance of sorts. One need look no further than Harlem, where the Walt Disney Co is planning to build a multimillion-dollar complex that will transform a neglected area into a major shopping district, to see that areas less attractive to business are becoming economically fashionable. In contrast, the economic distance between rich and poor has rarely, if ever, been greater, and it has been accompanied by steady increases in the numbers of uninsured individuals throughout the 1990s. Moreover,

efforts to improve the health of urban residents face new uncertainties: the fallout from welfare reform and work-fare initiatives; the promise of increased employment and, with it, questions about employer-based coverage of health care for low-wage workers; the increasing role of managed care in both private insurance and Medicaid; and questions about the fate and mission of providers and organizations that have come to be known as the urban safety net.

This commentary discusses how current access to health care in the nation's cities is related to the health of urban residents. It revisits the challenges facing health care providers and policymakers in addressing the problems of populations lacking adequate health care access and presents results from selected investigations that correlate the positive relationship of improved access, health care use, and health. A final section considers directions for future health services research, policy, and programs.

The Access Challenge: Scope and Consequences

Any effort to improve health care access and related outcomes in urban areas of the United States confronts substantial challenges in diseases and health-related circumstances, in pervasiveness of poverty, and in community and individual characteristics influencing the health care encounter.

Higher rates of adverse health and health-related conditions in the nation's central cities

reinforce the importance of improving health care access.[1] Between 1985 and 1995, 45 of the 100 largest cities experienced increases in low-birthweight infants exceeding 10%. In 1996, the tuberculosis rate for these cities was 3 times higher than that of their greater metropolitan areas and almost twice the rate for the nation overall. And while cities made remarkable strides during the 1990s in addressing violent crime, their rates are almost 3 times the suburban county rate (1437/100000 vs 486/100000 in 1996).

In comparison with their suburban counties, central cities in general have witnessed greater poverty rate increases, and they have led their surrounding areas in terms of poverty.[1] Poverty is associated with lack of health insurance, and extensive research documents that many uninsured individuals face major obstacles to care because of their inability to pay, including higher rates of preventable hospitalization in urban areas[2,3] and higher rates of adverse outcomes as measured by deaths and longer hospital stays.[4–6] Other work has further documented the access consequences associated with lack of insurance, including (1) a lower likelihood of having a regular source of care or well child care for uninsured children, (2) higher rates of postponed care and unfilled prescriptions among adults, and (3) fewer checkups, mammograms, and other preventive services and a greater likelihood of hospitalization for diabetes and other conditions.[7]

If ignored, individual and community characteristics can exacerbate urban access problems. Level of education, transportation, language and culture, proximity to health care providers, health literacy, and health beliefs are key factors that influence any effort to reach urban populations.[8,9] In addition, neighborhood conditions affect the breadth and type of access required. For example, a study of Harlem adolescents revealed elevated levels of exposure to diesel exhaust, which can aggravate or cause chronic lung disorders such as asthma.[10] Other investigations have highlighted how social and environmental characteristics contribute to mental disorders.[11] Such relevance is likely to extend to general health status.

Research has documented continuing, significant disparities in health services and outcomes affecting racial/ethnic populations. Studies focusing on racial/ethnic differences in courses of treatment for cardiac catheterization,[12] colorectal cancer,[13,14] and early-stage lung cancer[15] as well as hospitalizations for asthma[16] also imply that access challenges extend far beyond insurance status. Such results suggest that poor quality of care is more likely to affect outcomes than biology or genetic characteristics.

What do these findings mean in the context of access to health care generally and in particular for the metropolitan areas of the United States? Progress through Medicaid and other actions have reduced inequities in access to care[17]; among certain populations, however, substantial and continued income and insurance inequities remain a glaring part of the urban landscape.

Many concerned with health care assume that there is a direct association between improved access and improved health. Proving this direct relationship, however, presents its own challenges in determining causal links whereby a specific intervention can be credited with reducing adverse health effects or preventing certain conditions. As a result, while a number of investigations have focused on process measures (e.g., health care use), fewer have attempted to establish the link with outcomes (improved health or absence of preventable illness).

Insurance-related studies have indicated that Medicaid-enrolled individuals who are in poor health have greater numbers of health care visits than uninsured individuals in poor health[17] and that Medicaid enrollees are more likely to have appropriate prenatal care visits.[4] A Seattle-based investigation demonstrated that being insured was significantly correlated with having a regular source of care and with ease of health care access,[18] while a study of Atlanta public hospital patients without insurance and transportation revealed greater delays in receiving care.[8]

Investigations linking access and health outcomes have tended to focus on infants and children in both urban and other areas. This research has documented the positive effect on birth outcomes of enhanced prenatal services for low-income women.[19,20] And studies involving children and adolescents have linked health insurance with increased access and reductions in unmet or delayed care.[21]

Other investigations have also concluded that enrollment in Medicaid after being uninsured leads to improved health status.[18] Perhaps one of the most dramatic instances of the relationship between improved access and positive outcomes is the effect of broader financing for innovative treatment of HIV disease.[22] According to the Centers for Disease Control and Prevention, such findings represent the first downturn in related opportunistic infections.[23]

While these investigations provide evidence that insurance is an essential ingredient in improving access and outcomes, it is not the sole factor needed to improve the health of urban populations.[24,25] While Medicaid and other health reforms must continue to offer financial access, health services, research, and policy must integrate insurance with personal and community determinants.

Directions for Improving the Health of Urban Populations

Efforts to improve health by increasing access to health care in urban areas will need to continue targeting historically disenfranchised individuals—as identified by such factors as poverty, race/ethnicity, and education—but must also adapt to population changes brought on by demographic shifts and national policies such as welfare reform. Financing of care for underserved urban populations is likely to evolve in 2 directions: further devolution to state/local control and, at the same time, reassessments of support levels, influenced by decreases in support related to the Balanced Budget Amendment. Major uncertainty will also continue about application of tobacco dollars and how states use their own funds.

This section identifies 3 areas for addressing health care access issues of urban communities: demographic and social change, health service in the context of an evolving but uncertain delivery system, and the role of government and state or national policies affecting urban areas.

Urban Populations and the Responsibility of the Health Care System

The health care delivery system should establish priorities that recognize the significant changes occurring among urban populations and their communities. As discussed subsequently, culturally diverse populations and the elderly are 2 urban groups likely to increase well into the 21st century. Changes in welfare create new concerns, while health literacy is becoming a greater challenge given population dynamics and increased complexities in health care.

Cultural diversity. Both the growing diversity of the nation's urban areas and statistics concerning race/ethnicity and health care outcomes support the need for health professionals to understand the characteristics of these populations, to identify effective ways to deliver services, and to focus on health beliefs, customs, attitudes, behaviors, and perceptions that affect their willingness to seek and continue in treatment. These changes will also require health care organizations to more directly incorporate community perspectives into their health programs. Research should assess benefits of these actions in terms of both patient care and costs and savings in health care delivery.

The elderly population in the nation's cities. Many health care providers and organizations have long recognized the need for outreach into the areas where people work and live. As the number of elderly people in America increases, health care providers and organizations must be prepared to reach out to a growing, frequently poor population that, as a result of physical inability and community or psychological barriers (e.g., perceived threat of violence, confusion or fear), may find it increasingly difficult to leave their immediate environment. Such "naturally occurring retirement communities" will call for significant extension of care into these settings as well as cross-sectional skills that incorporate geriatrics, cultural diversity, poverty-related concerns, and familiarity with community characteristics. Government support of demonstrations and assessments of the efficacy of emerging models will assist in directing future service innovation.

Welfare–workplace transition and access to health care. With the introduction of urban residents formerly on welfare into the workforce, health care program administrators and policymakers will need to consider how to create access to health care in settings where the welfare-to-work population both resides and is employed. Employers may be interested in working with providers sufficiently familiar with this new group to offer care that minimizes time away from work owing to sick days and difficulty in accessing health services (e.g., offering or expanding weekend or evening clinic hours). Research could target employment and availability of insurance, focusing on productivity and absenteeism as they are linked to primary care access.

Health literacy and urban populations. Estimates suggest that almost 50% of US adults have less than adequate literacy skills for functioning in society, a fact that also significantly affects the ability to understand and navigate the health system.[26] Health literacy cuts across the urban sociodemographic spectrum as well, touching the elderly, culturally/ethnically diverse communities, immigrants, and those in poverty. Along with its implications for individuals, health literacy has far-reaching implications for practitioners, health care organizations, the pharmaceutical industry, health plans, and all levels of government in terms of morbidity and mortality, costs, and service delivery.

Improving health literacy will increase in importance in regard to patient–provider interactions, adherence to treatment, and home care and self-care. As such, research and program innovations should target improvements in the understanding of care and treatment. In this context, health literacy will also require government and private-sector support so that the health system can learn and adapt ways of informing and caring for a large and growing segment of the US population.

Reassessment of the Urban Safety Net: The Changing Role of Traditional Providers of Care

As new federal, state, and local health care strategies lead to new configurations or realignments of traditional safety net services in the nation's cities (e.g., closures or conversions of urban public hospitals), tracking these changes can help identify adverse effects as well as potential models. For example, policymakers should consider how access to quality health care is affected by the new alliances being forged by managed care and community health centers. Investigations should track over time such changes and monitor the impact on vulnerable populations in urban areas as well as the availability of essential services for the community at large. In addition, it will be important to document successes of safety net–managed care collaborations in improving comprehensiveness and continuity of care for inner-city populations.

Currently, many cities across the country are experimenting with public–private enhanced financing and service strategies to incorporate the uninsured into managed care. An example of such an effort is the county tax increase in Tampa, Fla, applied to incorporating previously uninsured individuals into a broad provider network in the urban area that extends beyond the traditional safety net provider. Absent a national health insurance initiative, policymakers should work to encourage, but carefully assess, these and other efforts to ensure and provide a sustainable system of care for this historically disenfranchised population. Without such initiatives, many providers and managed care plans will be forced to continually view vulnerable populations as not part of their mission.

Community intervention. Urban models are emerging that extend health care beyond clinic or hospital walls to integrate a community-based mission, orientation, and strategy into urban health. For example, the Parkland Health and Hospital System (Dallas) community program works through a network of health centers, homeless shelters, school health settings, churches, and senior citizens' centers.[27] Staffing objectives incorporate diversity and language that match the populations. The program has targeted major health and public health challenges such as preventive programs for cancer, immunizations, and maternal and child health.

An ongoing assessment strongly suggests that Parkland's reorientation benefits both health care providers and residents. It has resulted in an almost two-thirds reduction in emergency room use and hospitalization for diabetes, hypertension, and asthma. Its focus on access to community services and a walk-in clinic for the working poor is credited in large part for the shorter average length of hospital stay among these patients (3.4 hospital days) than among individuals not participating in the program (5.4 days). In addition, charges have been shown to be 50% lower among the former than the latter.[27] The initiative has also shifted emphasis from sickness to direct more attention to prevention and concerns related to primary care.

The Parkland initiative is part of a growing recognition that health care organizations, policymakers, and providers must work with communities to create a healthier environment. Quality-of-care studies linking processes of care to improved outcomes support this direction, emphasizing that critical characteristics outside the health system are frequently not considered to be a part of intervention designs.[28] Conversely, omission of these community-level "antecedents of medical care"—environment, culture, age, literacy—can limit the effectiveness of interventions and distort measurement of effects.

Health care interventions might be considered along a range of actions that the community deems critical to its health (e.g., trash removal, elimination of roach infestation, prevention of violence); these would be seen as points of entry to improving health and combating specific conditions such as asthma, trauma, and diseases. Research on the outcomes of these extended interventions should focus on identifying potential models wherein community–provider collaborations and knowledge of urban populations can yield greater health improvements.

Averting the health professional crisis in America's urban areas. There is a high likelihood that the numbers of underserved and diverse populations in urban areas will remain substantial—if not increase—in the foreseeable future. Of particular concern is the increasing erosion of affirmative action. This loss is likely to have a major untoward effect on the availability of urban health care; research has suggested that providers from diverse ethnic and cultural backgrounds tend to serve diverse and poor populations and that managed care may discourage plan participation by minority and other providers who treat these urban populations.[29]

It will not suffice to remove such an important means of reaching underserved urban communities—offering nothing but "hope for the best" in its place—and turn away from

the strong, straightforward evidence that culturally diverse providers simply tend to care for individuals from culturally diverse communities more than those who are not from such backgrounds. In other areas, such as education, steps have been taken to reduce negative effects (e.g., implementation of a "10% rule" in Texas by which the top 10% of students in state high schools are admitted to the public university).[30] The private sector and governments should use both resources and leverage to stanch this erosion as well.

Public Policy and the Role of Government

Health and social services programs suffer from long-standing, serious fragmentation and lack of coordination.[31] Solutions to problems in urban settings require cutting across categorical program lines, developing strategies and creating common data banks that extend across health and social settings.[32] California and other states are working to address this need directly by requiring managed care organizations accepting Medicaid enrollees to establish memorandums of understanding with public health agencies for the provision of public health services in regard to specific health education efforts (e.g., tuberculosis).[33]

States could use these "community benefit" mechanisms to encourage more active collaborations with local governments and providers. Initiatives could include devising strategies to address and monitor progress in alleviating health concerns in urban areas. The primary intent is not to make unreasonable demands but to encourage more direct, targeted initiatives around urban health challenges and problems.

The action taken in California to incorporate cultural competence requirements into Medi-Cal managed care contracts offers an example of a state moving health care organizations toward meeting the needs of growing and frequently underserved populations in urban and other areas. As of 1997, 12 primarily urban counties met threshold (3000 beneficiaries per language group) or concentration (1000 beneficiaries per zip code or 1500 beneficiaries in 2 contiguous zip codes) standards. Managed care organizations must provide linguistic services in these areas if they are to meet contracting requirements.[34]

Other requirements include 24-hour access to interpreter services and information on such topics as health education, plan coverage, and appointment scheduling. However, these provisions go beyond language to require creation of community advisory committees for guiding development and monitoring of culturally competent services,

conducting internal needs assessments, and formulating strategies for meeting linguistic and cultural needs. Other states—Minnesota, Massachusetts, and New Jersey, to name a few—are also developing cultural competence initiatives.

Finally, because financial support must accompany many of these efforts, states and communities will need to develop new resources or creatively apply existing dollars. Tobacco settlements represent one potentially significant source. Early indications from a National Conference of State Legislatures survey are that more than 40 states intend to apply at least some portion of the substantial tobacco settlement to improving health care.[35] (For example, Texas, along with 3 other states, will divide $40 billion over several years.)

Moreover, with the failure of the latest universal access proposal from the Clinton administration, many communities have developed, and others are likely to undertake, financially supported initiatives to improve access to health care for the uninsured. In fact, a study of 20 such programs revealed a spectrum ranging from formalizing voluntary community efforts to implementing managed care for the uninsured.[36] However, the tobacco-supported initiatives and many of these programs for the uninsured may share a common fate: fragility in regard to ability to maintain current levels of services over time owing to political and financial changes, especially in the event of an economic downturn.

Conclusions

These newly emerging efforts on the part of states may offer concrete directions for community benefit requirements and other ways to encourage providers and health care organizations to address urban health care challenges, because the principles—thresholds of need, specific services, community involvement, strategy development, and monitoring for effectiveness—can all be applied to health care priorities more broadly. However, the rapidly changing world of health care, the dynamic environments of the nation's urban areas, and time- or financially limited support—especially for the uninsured—require more than the idiosyncratic application of promising initiatives to achieve sustainable, long-lasting effects. Rather, these dynamics call for a national effort to develop and financially support replicable strategies that recognize the changing urban landscape and take advantage of collaborations among traditional and new players to set an effective agenda for improving access in cities across the United States.

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